FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0028605

Facility Name: Rest Haven West Christian Nursing Center

Address: 3450 Saratoga Avenue (Number) Downers Grove (City) 60515 (Zip Code)

County: DuPage

Telephone Number: (630) 969-2000 **Fax #** (630) 969-2148

IDPA ID Number: 362382853003

Date of Initial License for Current Owners: 05/01/84

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501 (C) 3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christine Hanover **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	145	Skilled (SNF)	145	52,925	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	96	Sheltered Care (SC)	96	35,040	5
6		ICF/DD 16 or Less			6
7	241	TOTALS	241	87,965	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,095	678	8,704	10,477	8
9	SNF/PED					9
10	ICF	15,670	21,295	13	36,978	10
11	ICF/DD					11
12	SC		33,575		33,575	12
13	DD 16 OR LESS					13
14	TOTALS	16,765	55,548	8,717	81,030	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.12%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/84

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/84 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 145 and days of care provided 7,803

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	682,026	92,193		774,219		774,219		774,219			1
2	Food Purchase		501,405		501,405		501,405	(13,545)	487,860			2
3	Housekeeping	171,065	29,925		200,990		200,990		200,990			3
4	Laundry	90,611	20,988		111,599		111,599		111,599			4
5	Heat and Other Utilities			196,196	196,196		196,196	6,320	202,516			5
6	Maintenance	177,759		209,821	387,580		387,580	(28,434)	359,146			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,121,461	644,511	406,017	2,171,989		2,171,989	(35,659)	2,136,330			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	3,288,958	249,513	13,091	3,551,562		3,551,562		3,551,562			10
10a	Therapy			695,551	695,551		695,551	(29,245)	666,306			10a
11	Activities	142,356	19,402	1,444	163,202		163,202		163,202			11
12	Social Services	169,747	118	2,396	172,261		172,261		172,261			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,601,061	269,033	726,882	4,596,976		4,596,976	(29,245)	4,567,731			16
	C. General Administration											
17	Administrative	132,982		397,655	530,637		530,637	(397,655)	132,982			17
18	Directors Fees											18
19	Professional Services			25,634	25,634		25,634	3,488	29,122			19
20	Dues, Fees, Subscriptions & Promotions			34,707	34,707		34,707	4,528	39,235			20
21	Clerical & General Office Expenses	630,340	22,546	55,790	708,676		708,676	62,570	771,246			21
22	Employee Benefits & Payroll Taxes			831,438	831,438		831,438	72,911	904,349			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,878	11,878		11,878	5,099	16,977			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			92,034	92,034		92,034	4,655	96,689			26
27	Other (specify):*											27
28	**TOTAL General Administration**	763,322	22,546	1,449,136	2,235,004		2,235,004	(244,404)	1,990,600			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,485,844	936,090	2,582,035	9,003,969		9,003,969	(309,308)	8,694,661			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000. SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Rest Haven West Christian Nursing Center #0028605 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			543,098	543,098		543,098	179,637	722,735			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			297,624	297,624		297,624	6,580	304,204			32
33	Real Estate Taxes			16,646	16,646		16,646	(14,445)	2,201			33
34	Rent-Facility & Grounds							10,453	10,453			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			857,368	857,368		857,368	182,225	1,039,593			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		682,701		682,701		682,701		682,701			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,208	79,208		79,208		79,208			42
43	Other (specify):* Nonallowable Costs			284,514	284,514		284,514	(284,514)				43
44	**TOTAL Special Cost Centers**		682,701	363,722	1,046,423		1,046,423	(284,514)	761,909			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,485,844	1,618,791	3,803,125	10,907,760		10,907,760	(411,597)	10,496,163			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(13,545)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	148,066	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(367)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(394)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(104,701)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(46,463)	43		28
29	Other-Attach Schedule See Schedule 5A	(228,242)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (245,646)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(165,951)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (165,951)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (411,597)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name	**Rest Haven West Christian Nursing Center**
PROVIDER #	**0028605**
Period Ending	**12/31/2002**

Schedule 5A

VI. ADJUSTMENT DETAIL

LINE 29 - Other

Description	Amount	Schedule V Reference
Disallow Dues	(800)	20
Residents Welfare	(9,662)	43
Uniform Income Offset	(456)	22
Miscellaneous Income Offset	(9,573)	21
Church/Civic	(1,026)	43
Trade Show	(230)	43
Gift Gratuities	(344)	43
Directories	(1,058)	43
Interehab Physiatry	(69,525)	43
Disallow Real Estate Tax	(16,646)	33
Medicare Laboratory	(45,269)	43
Medicare X-Ray	(5,869)	43
Disallow out-of-state travel	(7,306)	24
Disallow related party therapy	(29,245)	10A
Capitalize repairs & maintenance	(31,233)	6
Total	**(228,242)**	

See Accountants' Compilation Report

STATE OF ILLINOIS

Rest Haven West Christian Nursing Center

ID# 0028605

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Rest Haven West Christian Nursing Center **#** 0028605 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(13,545)	0	0	0	0	0	0	0	0	0	0	(13,545)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	6,320	0	0	0	0	0	0	0	0	0	6,320	5
6	Maintenance	0	2,799	0	0	0	0	0	0	0	0	0	2,799	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(13,545)	9,119	0	0	0	0	0	0	0	0	0	(4,426)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(397,655)	0	0	0	0	0	0	0	0	0	(397,655)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(394)	3,882	0	0	0	0	0	0	0	0	0	3,488	19
20	Fees, Subscriptions & Promotions	0	5,328	0	0	0	0	0	0	0	0	0	5,328	20
21	Clerical & General Office Expenses	0	72,143	0	0	0	0	0	0	0	0	0	72,143	21
22	Employee Benefits & Payroll Taxes	0	73,367	0	0	0	0	0	0	0	0	0	73,367	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	12,405	0	0	0	0	0	0	0	0	0	12,405	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	4,655	0	0	0	0	0	0	0	0	0	4,655	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(394)	(225,875)	0	0	0	0	0	0	0	0	0	(226,269)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(13,939)	(216,756)	0	0	0	0	0	0	0	0	0	(230,695)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	148,066	31,571	0	0	0	0	0	0	0	0	0	179,637	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	6,580	0	0	0	0	0	0	0	0	0	6,580	32
33	Real Estate Taxes	0	2,201	0	0	0	0	0	0	0	0	0	2,201	33
34	Rent-Facility & Grounds	0	10,453	0	0	0	0	0	0	0	0	0	10,453	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	148,066	50,805	0	0	0	0	0	0	0	0	0	198,871	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(151,531)	0	0	0	0	0	0	0	0	0	0	(151,531)	43
44	**TOTAL Special Cost Centers**	(151,531)	0	0	0	0	0	0	0	0	0	0	(151,531)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(17,404)	(165,951)	0	0	0	0	0	0	0	0	0	(183,355)	45

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Rest Haven Illiana Christian Convalescent Home	100%	Rest Haven Central	Palos Heights	Holland Home	South Holland	Sheltered Care
		Rest Haven South	South Holland	Village Woods	Crete	Independent Ret.
				Providence Mgmt. & Development Co.	Tinley Park	Management Co.
				Providence Home Health Care	Tinley Park	Home Health

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Rest Haven Illiana Christian Convalescent Home	100.00%	$ 6,320	$ 6,320	1
2	V	6	Maintenance supplies		Rest Haven Illiana Christian Convalescent Home	100.00%	2,799	2,799	2
3	V	17	Management fees	397,655	Rest Haven Illiana Christian Convalescent Home	100.00%		(397,655)	3
4	V	19	Professional services		Rest Haven Illiana Christian Convalescent Home	100.00%	3,882	3,882	4
5	V	20	Licenses, dues & subscriptions		Rest Haven Illiana Christian Convalescent Home	100.00%	5,328	5,328	5
6	V	21	Office		Rest Haven Illiana Christian Convalescent Home	100.00%	72,143	72,143	6
7	V	22	Employee benefits		Rest Haven Illiana Christian Convalescent Home	100.00%	73,367	73,367	7
8	V	24	Travel & seminar		Rest Haven Illiana Christian Convalescent Home	100.00%	12,405	12,405	8
9	V	26	Insurance		Rest Haven Illiana Christian Convalescent Home	100.00%	4,655	4,655	9
10	V	30	Depreciation		Rest Haven Illiana Christian Convalescent Home	100.00%	31,571	31,571	10
11	V	32	Interest Expense		Rest Haven Illiana Christian Convalescent Home	100.00%	6,580	6,580	11
12	V	33	Real Estate Taxes		Rest Haven Illiana Christian Convalescent Home	100.00%	2,201	2,201	12
13	V	34	Rent		Rest Haven Illiana Christian Convalescent Home	100.00%	10,453	10,453	13
14	Total			$ 397,655			$ 231,704	$ * (165,951)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5		N/A - Voluntary Board with no compensation. See attached Schedule 7A									5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Rest Haven Illiana Christian Conv. Home
Street Address: 18601 North Creek Drive
City / State / Zip Code: Tinley Park, IL 60477
Phone Number: (708) 342-8100
Fax Number: (708) 342-8006

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities-West	Accumulated Cost	70,056,582	15	$ 43,076	$	8,999,548	$ 5,534	1
2	5	Utilities-Saratoga	Accumulated Cost	70,056,582	15	43,076		1,278,411	786	2
3	6	Maintenance Supp.-West	Accumulated Cost	70,056,582	15	19,076		8,999,548	2,451	3
4	6	Maintenance Supp.-Saratoga	Accumulated Cost	70,056,582	15	19,076		1,278,411	348	4
5	19	Professional Fees-West	Accumulated Cost	70,056,582	15	26,458		8,999,548	3,399	5
6	19	Professional Fees-Saratoga	Accumulated Cost	70,056,582	15	26,458		1,278,411	483	6
7	20	Licenses, Dues-West	Accumulated Cost	70,056,582	15	36,315		8,999,548	4,665	7
8	20	Licenses, Dues-Saratoga	Accumulated Cost	70,056,582	15	36,315		1,278,411	663	8
9	21	Office-West	Accumulated Cost	70,056,582	15	491,744		8,999,548	63,170	9
10	21	Office-Saratoga	Accumulated Cost	70,056,582	15	491,744		1,278,411	8,973	10
11	22	Employee Benefits-West	Accumulated Cost	70,056,582	15	449,002		8,999,548	57,679	11
12	22	Employee Benefits-Saratoga	Accumulated Cost	70,056,582	15	449,002		1,278,411	8,194	12
13	22	Employee Benefits-West	Direct Cost	1	1	72,204		1	6,220	13
14	22	Employee Benefits-Saratoga	Direct Cost	1	1	72,204		1	1,274	14
15	24	Travel & Seminar-West	Accumulated Cost	70,056,582	15	84,558		8,999,548	10,862	15
16	24	Travel & Seminar-Saratoga	Accumulated Cost	70,056,582	15	84,558		1,278,411	1,543	16
17	26	Insurance-West	Accumulated Cost	70,056,582	15	31,733		8,999,548	4,076	17
18	26	Insurance-Saratoga	Accumulated Cost	70,056,582	15	31,733		1,278,411	579	18
19	30	Depreciation-West	Accumulated Cost	70,056,582	15	215,192		8,999,548	27,644	19
20	30	Depreciation-Saratoga	Accumulated Cost	70,056,582	15	215,192		1,278,411	3,927	20
21	32	Interest Expense-West	Accumulated Cost	70,056,582	15	44,853		8,999,548	5,762	21
22	32	Interest Expense-Saratoga	Accumulated Cost	70,056,582	15	44,853		1,278,411	818	22
23	33	Real Estate Taxes-West	Accumulated Cost	70,056,582	15	15,001		8,999,548	1,927	23
24	33	Real Estate Taxes-Saratoga	Accumulated Cost	70,056,582	15	15,001		1,278,411	274	24
25	TOTALS					$ 3,058,424	$		$ 221,251	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Rest Haven Illiana Christian Conv. Home
Street Address: 18601 North Creek Drive
City / State / Zip Code: Tinley Park, IL 60477
Phone Number: (708) 342-8100
Fax Number: (708) 342-8006

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	34	Rent-West	Accumulated Cost	70,056,582	15	$ 71,248	$	8,999,548	$ 9,153	1
2	34	Rent-Saratoga	Accumulated Cost	70,056,582	15	71,248		1,278,411	1,300	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 142,496	$		$ 10,453	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Tax Exempt Bonds		x	Additions and renovations	Varies	02/26/97	$ 5,515,700	$ 5,149,000	07/01/12	0.0536	$ 291,404	1
2	Notes		x	Facility Improvements	Various	Various	763,564	51,113	Various	Variable	6,220	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 6,279,264	$ 5,200,113			$ 297,624	9
	B. Non-Facility Related*											
10								Allocated from Home Office			6,580	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 6,580	14
15	TOTALS (line 9+line14)						$ 6,279,264	$ 5,200,113			$ 304,204	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # n/a

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	**Allocated from Home Office**	$ 2,201	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 2,201	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

Real estate taxes are allocated from a for-profit management entity.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rest Haven West Christian Nursing Center COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0028605

CONTACT PERSON REGARDING THIS REPORT Bill DeYoung

TELEPHONE (708) 342-8100 FAX #: (708) 342-8006

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not b entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-09-01-203-003-0000	New Home Office Building	$ 15,001.00	$ 2,201.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 15,001.00	$ 2,201.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? X YES _____ NO ***See Page 8 for Allocation***

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills** ***Real estate taxes are accrued, bill has not yet been received on the new building.***

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 105,900 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs: None
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	29,200	1984	$ 339,570	1
2					2
3	TOTALS	29,200		$ 339,570	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	241		1984	1962	$ 86,903	$	40	$	$	$ 86,903	4
5				1972	889,527	22,238	40	22,238		689,378	5
6				1973	34,742	869	40	869		26,070	6
7				1974	7,414	185	40	185		5,365	7
8				1975	55,878	1,397	40	1,397		39,116	8
	Improvement Type**										
9	Improvement			1976	4,115	103	40	103		2,781	9
10	Improvement			1977	33,527	838	40	838		21,788	10
11	Improvement			1980	6,049	151	40	151		3,473	11
12	Improvement			1981	7,380	185	40	185		4,070	12
13	Improvement			1983	22,839	571	40	571		11,420	13
14	Improvement			1984	253,714	9,250	40	9,250		148,153	14
15	Improvement			1985	297,491	7,437	40	7,437		133,866	15
16	Improvement			1986	275,406	6,885	40	6,885		117,045	16
17	Improvement			1987	24,035	601	40	601		9,616	17
18	Improvement			1988	509,896	12,747	40	12,747		191,205	18
19	Improvement			1989	4,381,420	109,536	40	109,536		1,533,504	19
20	Improvement			1989	90,660	2,267	40	2,267		31,738	20
21	Improvement			1990	155,196	3,880	40	3,880		50,440	21
22	Improvement			1991	5,021	126	40	126		1,512	22
23	Improvement			1992	75,453	1,886	40	1,886		20,746	23
24	Improvement			1993	26,281	657	40	657		6,570	24
25	Improvement			1994	16,231	405	40	405		3,645	25
26	Improvement			1995	128,962	3,224	40	3,224		24,180	26
27	Sign and landscaping			1996	4,764	119	40	119		774	27
28	Fence			1996	1,565	40	40	40		260	28
29	Renovate laundry and break rooms			1996	4,400	110	40	110		715	29
30	Whirlpool tubs			1996	20,200	505	40	505		3,282	30
31	Side rails			1996	2,293	57	40	57		371	31
32	Phone system			1996	35,085	877	40	877		5,700	32
33	Parking Lot			1997	15,078	377	40	377		2,074	33
34	Landscaping			1997	10,839	271	40	271		1,490	34
35	Dining room renovation			1997	1,193	30	40	30		165	35
36	Hospitality room renovation			1997	34,830	871	40	871		4,790	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Activity / class room renovation	1997	$ 3,476	$ 87	40	$ 87	$	$ 478	37
38	Carpeting	1997	1,521	38	40	38		209	38
39	Railing	1997	500	13	40	13		71	39
40	Laundry / break room renovation	1998	6,864	172	40	172		774	40
41	Compressor	1998	917	92	10	92		414	41
42	Roof repair	1998	2,320	232	10	232		1,044	42
43	Alarm system	1998	1,056	106	10	106		477	43
44	Hospitality room renovation	1998	12,605	316	40	316		1,422	44
45	Carpeting	1998	76,503	15,300	5	15,300		68,850	45
46	Wallpaper	1998	40,287	8,058	5	8,058		36,261	46
47	Roofing	1999	208,749	20,874	10	20,874		73,059	47
48	Therapy room renovation	1999	23,731	2,374	10	2,374		8,309	48
49	Resident room lighting	1999	23,965	2,396	10	2,397	1	8,387	49
50	Phone upgrade	1999	2,470	248	10	248		868	50
51	Renovations	1999	47,385	4,738	10	4,738		16,585	51
52	New door on oxygen room	1999	1,993	194	10	194		680	52
53	Landscaping	2000	59,350	1,484	40	1,484		3,710	53
54	Benches	2000	2,500	63	40	63		157	54
55	Room 18 renovation, wallcover, painting, tiling and carpeting	2000	7,682	768	10	768		1,920	55
56	Therapy renovation, wallcover, painting and tiling	2000	28,849	2,885	10	2,885		7,212	56
57	Beauty renovation, wallcover, painting, tiling and carpeting	2000	31,764	3,176	10	3,176		7,940	57
58	Common renovation, wallcover, painting, tiling, and carpeting	2000	42,312	4,231	10	4,231		10,578	58
59	Kitchen renovation, wallcover, painting, and tiling	2000	24,995	2,500	10	2,500		6,250	59
60	HVAC	2000	32,028	3,203	10	3,203		8,007	60
61	Doors	2000	3,300	330	10	330		825	61
62	Countertop	2000	654	65	10	65		163	62
63	Sprinkler System	2001	39,878	997	40	997		1,495	63
64	Benches	2001	2,455	61	40	61		92	64
65	Room Renovations	2001	1,398,437	63,725	10	139,844	76,119	209,766	65
66	Rehab Renovations	2001	98,080	9,808	10	9,808		14,712	66
67	Nurse Call System	2001	114,755	11,476	10	11,476		17,214	67
68	Kitchen Renovations	2001	3,800	380	10	380		570	68
69	HVAC	2001	3,000	300	10	300		450	69
70	TOTAL (lines 4 thru 69)		$ 9,866,568	$ 349,385		$ 425,505	$ 76,120	$ 3,691,154	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 9,866,568	$ 349,385		$ 425,505	$ 76,120	$ 3,691,154	1
2	Doors	2001	3,187	319	10	319		478	2
3	Office Remodeling	2001	35,071	3,507	10	3,507		5,261	3
4	HVAC	2001	28,200	2,820	10	2,820		4,230	4
5	Carpeting	2001	6,612		10	661	661	992	5
6	Landscaping	2002	25,539	1,277	10	1,277		1,277	6
7	Fence	2002	4,675	235	10	235		235	7
8	Nurse Call Station Renovations	2002	26,950	337	40	337		337	8
9	HVAC	2002	12,424	155	40	155		155	9
10	Generator	2002	1,845		40	23	23	23	10
11	Renovations	2002	33,960	849	40	424	(425)	424	11
12	New Therapy Addition	2002	73,389	1,835	40	917	(918)	917	12
13	Landscaping	2002	10,400	260	40	130	(130)	130	13
14	Repair R3000 System	2002	3,922		40	49	49	49	14
15	Carpeting	2002	9,713		40	121	121	121	15
16									16
17									17
18									18
19									19
20									20
21	Allocated from Home Office	2002	607,842			4,392	4,392	7,784	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31	Book depreciation on assets disallowed for Medicaid			49,216			(49,216)		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,750,297	$ 410,195		$ 440,872	$ 30,677	$ 3,713,567	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,414,785	$ 121,288	$ 243,069	$ 121,781	3-10 yrs	$ 1,961,230	71
72	Current Year Purchases	232,291	11,615	11,615		10 yrs	11,615	72
73	Fully Depreciated Assets							73
74	Allocated from Home Office	403,073		26,919	26,919		159,096	74
75	TOTALS	$ 3,050,149	$ 132,903	$ 281,603	$ 148,700		$ 2,131,941	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	1984 Ford Bus	1989	$ 47,590	$	$	$	5	$ 47,590	76
77	Resident Care	1995 Chevrolet K20 Truck	1995	22,494				5	22,494	77
78										78
79	Allocated from Home Office			4,422		260	260		258	79
80	TOTALS			$ 74,506	$	$ 260	$ 260		$ 70,342	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 14,214,522	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 543,098	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 722,735	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 179,637	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,915,850	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

PLEASE ENTER ONLY DATES IN CELLS W16 AND W17

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Home Office Allocation				10,453			6
7	TOTAL				$ 10,453 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning N/A
Ending N/A

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$ N/A
13.	/2004	$ N/A
14.	/2005	$ N/A

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ N/A Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L. 10a C 8	hrs	$	5,672	$ 256,558	$	5,672	$ 256,558	1
2	Licensed Speech and Language Development Therapist	L. 10a C 8	hrs		546	82,096		546	82,096	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L. 10a C 8	hrs		5,955	327,652		5,955	327,652	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L. 39 C 2	# of prescrpts				682,701		682,701	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	12,173	$ 666,306	$ 682,701	12,173	$ 1,349,007	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,200	$ 1,200	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 306,733)	1,390,058	1,390,058	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	36,826	36,826	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,428,084	$ 1,428,084	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	358,918	339,570	13
14	Buildings, at Historical Cost	11,125,197	10,750,297	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,791,311	3,124,655	16
17	Accumulated Depreciation (book methods)	(6,562,772)	(5,915,850)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,712,654	$ 8,298,672	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,140,738	$ 9,726,756	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,194,487	$ 1,194,487	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	51,113	51,113	29
30	Accrued Salaries Payable	319,826	319,826	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,177	17,177	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	4,166,270	4,166,270	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,748,873	$ 5,748,873	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		5,149,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,149,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,748,873	$ 10,897,873	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,391,865	$ (1,171,117)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,140,738	$ 9,726,756	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name **Rest Haven West Christian Nursing Center**
PROVIDER # **0028605**
Period Ending **12/31/2002**

Schedule 17A

XV. BALANCE SHEET

C. Current Liabilities **Line 36, Other Current Liabilities (specify):**	Operating	After Consolidation
Dental Withholding	1,534	1,534
Health Insurance Withholding	11,657	11,657
TDA Withholding	32,285	32,285
Mony Life Insurance Withholding	(246)	(246)
Life Insurance Withholding	9	9
Standard Withholding	2,819	2,819
Child Support Withholding	2,343	2,343
T.S.A. Withholding	15	15
Misc. Payroll Withholding	184	184
Levy	(2,489)	(2,489)
Life Line Deposits	600	600
Due to Related Parties	4,117,559	4,117,559
Total	4,166,270	4,166,270

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,959,163	1
2	Restatements (describe):		2
3	**Prior Period Adjustments**	193,246	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,152,409	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	239,456	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 239,456	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,391,865	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,056,953	1
2	Discounts and Allowances for all Levels	(2,504,223)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,552,730	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,567,797	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,567,797	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	11,503	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	663,971	17
18	Sale of Supplies to Non-Patients	10,325	18
19	Laboratory	87,255	19
20	Radiology and X-Ray	10,550	20
21	Other Medical Services	229,214	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,012,818	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Schedule 19A	13,871	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,871	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,147,216	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,171,989	31
32	Health Care	4,596,976	32
33	General Administration	2,235,004	33
	B. Capital Expense		
34	Ownership	857,368	34
	C. Ancillary Expense		
35	Special Cost Centers	967,215	35
36	Provider Participation Fee	79,208	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,907,760	40
41	**Income before Income Taxes (line 30 minus line 40)****	239,456	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 239,456	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name **Rest Haven West Christian Nursing Center**
PROVIDER # **0028605**
Period Ending **12/31/2002**

Schedule 19 A

XVII. INCOME STATEMENT
E. Other Revenue

	Amount
Recreation Hall	1,800
Food/Vending	1,740
Other Income	9,573
Uniform Income	456
Employee Meals	302
Total	13,871

See Accountants' Compilation Report

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 64,590	$ 31.05	1
2	Assistant Director of Nursing	1,432	1,432	40,500	28.28	2
3	Registered Nurses	51,486	52,594	1,093,742	20.80	3
4	Licensed Practical Nurses	19,192	22,285	493,988	22.17	4
5	Nurse Aides & Orderlies	87,843	94,458	1,544,748	16.35	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,830	2,082	35,484	17.04	9
10	Activity Assistants	8,628	9,389	106,872	11.38	10
11	Social Service Workers	8,672	9,657	169,747	17.58	11
12	Dietician	1,928	2,080	55,577	26.72	12
13	Food Service Supervisor	1,858	2,026	36,160	17.85	13
14	Head Cook	1,825	2,033	27,306	13.43	14
15	Cook Helpers/Assistants	51,101	53,668	562,983	10.49	15
16	Dishwashers					16
17	Maintenance Workers	12,418	13,352	177,759	13.31	17
18	Housekeepers	15,043	15,997	171,065	10.69	18
19	Laundry	8,532	9,107	90,611	9.95	19
20	Administrator	2,080	2,080	77,663	37.34	20
21	Assistant Administrator	2,080	2,080	55,319	26.60	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	30,572	32,865	630,340	19.18	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,142	1,179	16,173	13.72	31
32	Other Health Ca See Sch20A	1,606	1,693	35,217	20.80	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	311,268	332,137	$ 5,485,844 *	$ 16.52	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	14,400	L9, C3	36
37	Medical Records Consultant	Monthly	4,128	L10, C3	37
38	Nurse Consultant	Monthly	7,223	L10, C3	38
39	Pharmacist Consultant	Monthly	1,740	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	40	1,444	L11, C3	44
45	Social Service Consultant	Monthly	2,244	L12, C3	45
46	Other(specify) Chapel Ministry	4	152	L12, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	44	$ 31,331		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		n/a		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name	**Rest Haven West Christian Nursing Center**
PROVIDER #	**0028605**
Period Ending	**12/31/2002**

Schedule 20A

XVIII. STAFFING AND SALARY COSTS

	Hours Worked	Hours Paid	Salary	Avg Hr Wage	Cost Report Line
Employee Educator	1,606	1,693	35,217	20.80	10
Total Line 32 - Other Health Care	**1,606**	**1,693**	**$ 35,217**	**$ 20.80**	

See Accountants' Compilation Report

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Catherine DeVries	Administrator	0%	$ 77,663
Linda Hart	Asst. Adminstr.	0%	55,319
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 132,982

B. Administrative - Other

Description	Amount
Management fees (eliminated in column 7)	$ 397,655
TOTAL (agree to Schedule V, line 17, col. 3)	$ 397,655
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Altschuler, Melvoin & Glasser LLP	Accounting	$ 7,730
Laner, Muchin, Dombrow	Legal	88
KPMG Peat Marwick LLP	Accounting	9,273
M.G.R. Legal Filing/Title Services	Legal	306
Amherst Senior Living Associates	Market Study Consulting	2,204
SMS	Medicare Billing	492
Providence Management Co.	Consulting	130
Linda Hart	Consulting	420
ProStaff	Consulting	2,431
Alternative Staffing Resource	Consulting	780
AMA Profile	Consulting	25
Chapman & Cutter	Legal	1,755
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 25,634

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 68,160
Unemployment Compensation Insurance	8,282
FICA Taxes	382,089
Employee Health Insurance	47,335
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	253,339
Employee Vaccinations/Medical	1,498
Drug Testing	2,620
TDA Expense	64,131
Employee Education	2,405
Uniforms	1,123
Home Office Allocation	73,367
TOTAL (agree to Schedule V, line 22, col.8)	$ 904,349

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 193
Advertising: Employee Recruitment	886
Health Care Worker Background Check	
(Indicate # of checks performed 34)	403
Life Services Network	24,339
Health Resources Alliance	3,333
Miscellaneous Licenses and Dues	3,896
Miscellaneous Subscriptions	857
Home Office Allocation	5,328
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 39,235

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,572
Home Office Allocation	12,405
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,977

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Rest Haven West Christian Nursing Center
Provider #: 0028605
01/01/02 to 12/31/02

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	25,634
Allocated from Home Office	
Legal	1,142
Other	2,740
Non-allowable Legal (M.G.R)	(306)
Non-allowable Legal (Laner, Muchin, Dambrow)	(88)
Total (agree to Schedule V, line 19, column 8)	29,122

See Accountants' Compilation Report

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3	N/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN: $24,339; HRA: $3,333**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **72,274** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **79,208**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **N/A** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **13,545**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG Peat Marwick LLP** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **Audit in Progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Rest Haven West Christi** **04:05 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-411,597	equal to	-411,597	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	304,204	equal to	304,204	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	2,201	equal to	2,201	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	722,735	equal to	722,735	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	10,453	equal to	10,453	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	0	equal to	0	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	666,306	equal to	695,551	-29,245	FAILED	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	682,701	equal to	682,701	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	2,171,989	equal to	2,171,989	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	4,596,976	equal to	4,596,976	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	2,235,004	equal to	2,235,004	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	857,368	equal to	857,368	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	967,215	equal to	967,215	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	79,208	equal to	79,208	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	3,253,741	equal to	3,288,958	-35,217	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	142,356	equal to	142,356	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	169,747	equal to	169,747	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	682,026	equal to	682,026	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	177,759	equal to	177,759	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	171,065	equal to	171,065	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	90,611	equal to	90,611	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	132,982	equal to	132,982	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	630,340	equal to	630,340	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	5,485,844	equal to	5,485,844	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	14,400	< or = to	14,400	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	13,091	< or = to	13,091	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	1,444	< or = to	1,444	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,244	< or = to	2,396	-152	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	132,982	equal to	132,982	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	397,655	equal to	397,655	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	25,634	equal to	25,634	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	904,349	equal to	904,349	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	39,235	equal to	39,235	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	16,977	equal to	16,977	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	79,208	equal to	79,208	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	72,911	-72,911	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	7,803	equal to	8,704	-901	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-165,951	equal to	-165,951	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	5,200,113	equal to	5,200,113	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	339,570	equal to	339,570	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	10,750,297	equal to	10,750,297	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	3,124,655	equal to	3,124,655	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	5,915,850	equal to	5,915,850	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	3,391,865	equal to	3,391,865	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	239,456	equal to	239,456	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	9,140,738	equal to	9,140,738	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	682,026	92,193	0	774,219	0	774,219	0	774,219
2. Food P	0	501,405	0	501,405	0	501,405	-13,545	487,860
3. Housek	171,065	29,925	0	200,990	0	200,990	0	200,990
4. Laundry	90,611	20,988	0	111,599	0	111,599	0	111,599
5. Heat ar	0	0	196,196	196,196	0	196,196	6,320	202,516
6. Mainter	177,759	0	209,821	387,580	0	387,580	-28,434	359,146
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	1,121,461	644,511	406,017	2,171,989	0	2,171,989	-35,659	2,136,330
9. Medical	0	0	14,400	14,400	0	14,400	0	14,400
10. Nursin	3,288,958	249,513	13,091	3,551,562	0	3,551,562	0	3,551,562
10a. Ther	0	0	695,551	695,551	0	695,551	-29,245	666,306
11. Activit	142,356	19,402	1,444	163,202	0	163,202	0	163,202
12. Social	169,747	118	2,396	172,261	0	172,261	0	172,261
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total H	3,601,061	269,033	726,882	4,596,976	0	4,596,976	-29,245	4,567,731
17. Admin	132,982	0	397,655	530,637	0	530,637	-397,655	132,982
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	25,634	25,634	0	25,634	3,488	29,122
20. Fees,	0	0	34,707	34,707	0	34,707	4,528	39,235
21. Clerica	630,340	22,546	55,790	708,676	0	708,676	62,570	771,246
22. Emplo	0	0	831,438	831,438	0	831,438	72,911	904,349
23. Inserv	0	0	0	0	0	0	0	0
24. Travel	0	0	11,878	11,878	0	11,878	5,099	16,977
25. Other	0	0	0	0	0	0	0	0
26. Insura	0	0	92,034	92,034	0	92,034	4,655	96,689
27. Other	0	0	0	0	0	0	0	0
28. Total (	763,322	22,546	1,449,136	2,235,004	0	2,235,004	-244,404	1,990,600
29. Total (	5,485,844	936,090	2,582,035	9,003,969	0	9,003,969	-309,308	8,694,661
30. Depre	0	0	543,098	543,098	0	543,098	179,637	722,735
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	297,624	297,624	0	297,624	6,580	304,204
33. Real E	0	0	16,646	16,646	0	16,646	-14,445	2,201
34. Rent -	0	0	0	0	0	0	10,453	10,453
35. Rent -	0	0	0	0	0	0	0	0
36. Other	0	0	0	0	0	0	0	0
37. Total (	0	0	857,368	857,368	0	857,368	182,225	1,039,593
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	682,701	0	682,701	0	682,701	0	682,701
40. Barbe	0	0	0	0	0	0	0	0
41. Coffee	0	0	0	0	0	0	0	0
42	0	0	79,208	79,208	0	79,208	0	79,208
43. Other	0	0	284,514	284,514	0	284,514	-284,514	0
44. Total S	0	682,701	363,722	1,046,423	0	1,046,423	-284,514	761,909
45. Grand	5,485,844	1,618,791	3,803,125	########	0	########	-411,597	########

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	1,200	1,200
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,390,058	1,390,058
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	36,826	36,826
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	1,428,084	1,428,084
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	358,918	339,570
14. Buildings, at Historical Cost	11,125,197	10,750,297
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	2,791,311	3,124,655
17. Accumulated Depreciation (book methods)	-6,562,772	-5,915,850
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	7,712,654	8,298,672
25. Total Assets	9,140,738	9,726,756
CURRENT LIABILITIES		
26. Accounts Payable	1,194,487	1,194,487
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	51,113	51,113
30. Accrued Salaries Payable	319,826	319,826
31. Accrued Taxes Payable	17,177	17,177
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	4,166,270	4,166,270
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	5,748,873	5,748,873
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	5,149,000
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	5,149,000
46.Total Liabilities	5,748,873	10,897,873
47.Total Equity	3,391,865	-1,171,117
48.Total Liabilities and Equity	9,140,738	9,726,756

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	10,056,953
2. Discounts and Allowances for all Levels	-2,504,223
Subtotal - Inpatient Care	7,552,730
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	2,567,797
7. Oxygen	0
Subtotal - Anciliary Revenue	2,567,797
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	11,503
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	663,971
18. Sale of Supplies to Non-Patients	10,325
19. Laboratory	87,255
20. Radiologyand X-Ray	10,550
21. Other Medical Services	229,214
22. Laundry	0
Subtotal - Other Operating Revenue	1,012,818
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	13,871
28. Other Revenue (specify):	0
Subtotal - Other Revenue	13,871
30. Total Revenue	11,147,216
31. General Services	2,171,989
32. Health Care	4,596,976
33. General Administration	2,235,004
34. Ownership	857,368
35. Special Cost Centers	967,215
35. Provider Participation Fee	79,208
37. Other	0
40. Total Expenses	10,907,760
41. Income Before Income Taxes	239,456
42. Income Taxes	0
43. Net Income or Loss for the Year	239,456

Page

Line 16 for mortgage insurance.